SEND ORIGINAL TO: INDUSTRIAL COMMISSION, JUDICIAL DIVISION, PO BOX 83720, BOISE, IDAHO 83720-0041

COMPLAINT FOR BENEFITS
UNDER
PEACE OFFICER & DETENTION OFFICER
TEMPORARY DISABILITY ACT
(Idaho Code § 72-1101, *et seq.*)

1. Complaining Officer (Name, Address and Telephone Number):	**1a**. Officer's Attorney (Name, Address and Telephone Number. If no attorney, write "NONE."):
2. Employer (Name, Address and Telephone Number):	**2a.** Employer's Attorney (Name, Address and Telephone Number. If no attorney, write "NONE."):

3. Officer's Social Security Number:	**4.** Officer's Birth date:	**5.** Date & Place of Injury:

6. Describe how injury occurred (what happened):

7. Start date and amount of workers' compensation weekly wage loss benefit being paid for this injury:	**8.** Average weekly wage (Gross & Net) being paid by Employer at the time of this injury:

9. Explain how the Officer's injury:

1. was incurred in the performance of the Officer's duties; when:
   a. responding to an emergency, **or**,
   b. in the pursuit of an actual or suspected violator of the law, **and by reason thereof,**
2. the Officer is temporarily incapacitated from performing the Officer's duties, **and**
3. qualifies the Officer for workers' compensation wage loss benefits under title 72, Idaho Code.

[Attach additional sheets as needed. Identify continuation of responses by Section Number. **Number of additional sheets attached:_____.**]

Date Signed:	Signature of Officer or Attorney:

CERTIFICATE OF SERVICE

I certify that on the ____ day of _____, 20__, I served a copy of this Complaint upon the __ Employer or __ Employer's Attorney by either: ___ personal service or ___ regular U.S. Mail at their address in § 2 or 2a, above. X _____

Print Name: _____

NOTICE: AN EMPLOYER SERVED WITH A COPY OF THIS COMPLAINT MUST FILE AN ANSWER WITH THE INDUSTRIAL COMMISSION WITHIN 21 DAYS TO AVOID ENTRY OF DEFAULT JUDGMENT. AN EMPLOYEE COMPLAINT FOR WORKERS' COMPENSATION BENEFITS MUST BE FILED SEPARATELY WITH THE INDUSTRIAL COMMISSION USING IC FORM 1001 (WORKERS' COMPENSATION COMPLAINT).